King/Drew Medical Center Workplan Implementation
Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 6/24/05

Initiative	Overall Progress Update	Total Recommend-ations Completed	Total DUE Action Steps Completed	Number of "Yellow" and "Red" Recommend-ations
		%	%	Count
Governance	HAB Board met June13. A report was given by the Chairman and reports were given from the Finance and Quality Committees. A report was also presented by Navigant Consulting, Inc on workplan progress. Old Business items were deferred due to lack of time, but were to have included a discussion and approval of bylaw revisions and a discussion on Community Involvement. These items are now agendized for July 11 meeting. New Business included appointment of a Nominating Committee to address two vacancies on the HAB. The ad hoc Steering Committee continues to meet weekly with management and addresses current issues as they arise.	86%	87%	2
Management/Structure	Recruitment of the executive positions is in progress. In the month of June, five (5) CEO candidates were interviewed; of those, two are recommended for further interviews.	100%	100%	0
Risk Management	The revised policy and procedure for close call/near miss, adverse event and sentinel event was presented to KDMC senior staff and the Quality Oversight Committee of the HAB. The process for submitting event notifications has been streamlined to promote more timely identification of incidents to risk management to support coordination of early follow-up. The Risk Management Director is participating in the Medication Event Task Force reviewing and analyzing medication events weekly to make recommendations on corrective actions. The UHC Patient Safety Net implementation is on target to begin implementation in August. The new procedure for case review and root cause analysis was finalized and presented to senior staff. A full inventory of outstanding cases requiring needed review or further information is being completed. A weekly Case Review and Response meeting has been instituted to review cases and ensure follow-up on outstanding information requirements and corrective actions. Data on the status of death reviews and follow-up; medication events; and falls are being reported weekly to executive management and the Steering Committee of the Board.	5%	67%	5
Regulatory	The hospital's plan of correction in response to the October, 2004 CMS survey, originally submitted May 12, was revised and resubmitted June 10 at the request of CMS. 107 Elements of Performance were reviewed with 70% being fully compliant and 15% being partially compliant. Responsible individuals are assigned to respond to the findings of the mock surveys and develop action plans to bring the organization into compliance with the deficiency. The results of mock surveys are communicated to executive management and the Regulatory Compliance Committee, which represents the oversight body for regulatory compliance activities. Results from mock surveys completed through May were communicated to the medical staff at the June 1 Medical Executive Committee meeting and at the June 6 quarterly Medical Staff (Professional Staff Association) Meeting. During these meetings, specific responsibilities of individual medical staff members to achieve regulatory compliance was stressed. The Regulatory Readiness Committee met June 6 and June 20. Committee members were assigned accountability for specific JCAHO functions/chapters and will report initial compliance with the standards within their respective functions/chapters at the next Regulatory Readiness Meeting scheduled for July 5. Bi-Weekly Patient Safety Leadership Walk Rounds were conducted June 7 and June 22 on two patient care units. Issues identified during these rounds are discussed by executive management at their cabinet meetings for follow-up. Issues identified to date include (but are not limited to): nursing staff requesting training on how to appropriately deal with verbally abusive patients; some staff expressing hesitancy to report errors or "near misses" for fear of punitive outcomes; space and maintenance/cleaning issues for equipment; and patient flow issues that could be resolved through better interdepartmental communication.	64%	90%	3

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	A new policy and procedure has been created to strengthen the process for creating, reviewing, and revising policies and procedures. The purpose of the policy is to: define the process for policy writing, revising, approval, and distribution; to ensure a consistent method of policy development, approval, formatting, and distribution throughout KDMC and to determine the need for new policies or policy revision; to identify if any other departments need to be involved in the development of, or are affected by, new policies or policy revision; to assure appropriate interdepartmental review and executive approval; to provide for staff education and communication related to new and/or revised policies; to identify clear accountabilities for the appropriateness and currency of policies; to ensure that all policies are consistent with JCAHO standards and federal, state, and local laws; and to establish a central policy resource as a vehicle for comprehensive, timely dissemination of policies. A task force has been created to redefine and streamline KDMC's policy and procedure manual structure to centralize review of all polices, consolidate and reduce the volume of policies and implement a process for posting policies and procedures to the intranet to ensure timely accurate dissemination to staff on new and revised policies.			
Performance and Quality Improvement	The Case Review and Response and Root Cause Analysis policy and procedure and tools have been completed and instituted. A draft of Hospital Quality Management Committee (HQMT) charter is drafted with their first meeting scheduled for July 31. The Quality Oversight Committee (QOC) of the HAB had there second meeting on June 22. Agenda items included: revised committee charter and membership; KDMC current accreditations/licenses/certificates; community health indicators; credentialing/privileging process; Pharmacy Quality Report; Performance Improvement Plan; and revised the Event Notification Policy. The quality performance measures and patient safety indicators were reviewed. A recommendations to include the National Quality Forum (NQF) list of 20 reportable events in event notification policies and procedures and patient safety education put in place.	22%	60%	20
Infection Control	The policy and procedure review and revision is moving forward. Over half of the policies that need to be reviewed and revised have been completed. Many have already been approved by the IC Committee. A competency checklist was developed for sterilization and high level disinfection. Each department manager who oversees these processes will be completing this competency, observation of practice and/or return demonstration, for employees in their area. All items necessary to convert to event related processing are in place, during the conversion both date and event related items will be in the work stream. Therefore policies governing both will need to be in place. Improvement efforts to ensure appropriate and timely isolation procedures are in place continues. Required isolation type will now be communicated in Affinity by nursing. The Affinity System will produce a census report including patients admitted during the previous 24 hours that can be used by the IC Practitioners to ensure that patients who require isolation are placed in isolation in a timely manner. Educational packets, which include information provided during the IC Health Fair, were given to all nurse managers to ensure that nurses who did not attend the fair, receive the training for cleaning of glucometers so they can complete the required return demonstrations. IC Practitioners have been conducting weekly infection control rounds (one unit per week) to monitor the general environment and cleanliness of individual patient rooms. The findings are sent to the accountable supervisors for corrective action.	76%	95%	1
Budget	The major steps necessary for the eCAPS conversion have been completed. All Labor Cost Distribution Schedules (LCDS) changes have been coordinated with HR and the Chart of Accounts has been updated to reflect the new coding structure.	0%	90%	0

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Productivity	A new Chart of Accounts has been established for eCAPS and is being finalized and loaded into the County Accounting system for implementation in FY 05-06. Employees were moved in CWTAPPS to align with the new chart. It is anticipated that in July and August, the labor cost will align more accurately with the new structure. After the new cost center structure is finalized and data is validated, Finance and IS will work to test run Unit of Service statistics, utilizing Affinity data source as much as practically possible. In parallel, Finance will work with executive management to review and select job positions that are included for the productivity monitoring tool. The time frame of the implementation of productivity monitoring tool may need to be modified to make the efforts coordinated in relation to the scheduled eCAPS implementation.	0%	75%	4
Space Planning	OR renovation plans were approved by DHS including the use of interim space such as the trauma ORs and the one C-section procedure room. OSHPD approval is expected within 7-14 days. Very little progress has been made in the Psychiatry renovations these will not be substantially complete prior to JCAHO for the entire building. County DHS has informed us that the relocation of all Outpatient (OP) Pharmacy to the second floor of trauma on a permanent basis is not an option and that there is are no funds available to spend on further renovations. We were informed that OP Pharmacy must return to the first floor, politically a permanent relocation to Women's Health is not possible, and can make very minor/low cost repairs. This is a major patient care and patient flow issue. While funds have been transferred to capital projects the failure to authorize expenditure creates additional barriers and will slow down the process.	20%	63%	1
Environment of Care	The bulletin for the recruitment of an experienced Safety Officer was posted. The (7) EOC 2005 Safety Management Plans have been reviewed and the current content and format will meet JCAHO requirements. The plan is to cross-walk these plans with applicable policies and procures and make the revisions to them.	64%	66%	6
Facilities Management	Three new equipment training modules for nurses have been developed: Basic Principles of Patient Monitoring; Systems for Remote Patient; and Electrical Safety in Hospitalized Patients. Two of the modules have been rolled out, a third is scheduled to start July 18. The Basic Principles of Patient Monitoring curriculum will consist of 2 hours of didactic presentation (Part 1) and 2 hours of hands-on training (Part 2) that will cover 1) Bedside Component Monitor (Basic Set-up with Alarm Functions); 2) ECG Monitoring with Heart Rate Computer; 3) Non-invasive Blood Pressure (NBP) Monitoring; 4) Respiratory Monitoring; 5) Pulse Oximetry (SpO2) Monitoring; 6) Temperature Monitoring; and 7) Trending of Vital Sign Measurements. The participants who enroll in Part 1 of will be expected to complete Part 2 a skills checklist and a post-test that will result in the receipt of a competency certificate by the participants. An in-house refurbishment program has been implemented for the facility. Painting requirements will be identified through inspections and other refurbishing is handled and identified through routine walk-through rounds. An overall Major Facility Capital Project refurbishment request has been submitted to the BOS for approval of funds. The regulatory agencies and requirements have been identified and organized to ensure compliance. New policies and procedures for the cleaning of medical equipment have been instituted and the training of staff completed.	33%	86%	3

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Materials Management	Efforts at recruitment continue. Training for OLR (On Line Requisition) has started. The move of the invoice processing function to Rancho has been delayed until November due to necessary coordination with the implementation of eCAPS. The Product Evaluation/Standardization Committee charter has been approved. The team will provide a mechanism to ensure an improved level of patient care through product evaluation with emphasis on the quality of care and the containment of costs. They are charged with the evaluation of all new products and to minimize the dollar investment in inventory by reducing the variety of products. The Value Analysis Facilitator (VAF) and the Director of Materials Management will serve as staff to this committee and will monitor the product quality control activities, to include vendor access to Southwest Area buildings. This group will meet to review products/supplies referred for evaluation. Specifically, they will be responsible to: support the standardization of medical supplies used throughout the Southwest Area, when possible; evaluate, approve, or disapprove for purchase, requests for new products; decide how the product should be made available ; evaluate various medical products referred by the Los Angeles County Purchasing Department and outside vendors; investigate and resolve problems created by existing inferior/defective medical products; and remove from the accepted list of medical products those items, which are no longer in use or have proven to be hazardous and non-efficacious.	18%	73%	6
Contracted Services (Respiratory)	The new ventilator weaning protocol and policy was approved the Medical Executive Committee with an anticipated implementation August 1. Education has started. A respiratory therapist has been added to the membership of the interdisciplinary Medication Event Task Force to improve reporting of incidents involving respiratory medications and to provide input into the corrective action plans to resolve issues.	50%	100%	0
Contracted Services (Dietary)	Overall the action steps have been completed on target and the work plan is on schedule.	57%	100%	0
Contracted Services (Security)	Overall, the implementation of the revised policies and procedures with regards to restraints (Code 9) has made a significant improvement in the managing of aggressive patient behaviors. It has placed more responsibility and emphasis on the medical and/or psychiatric staff to provide interventions prior to requesting police assistance. This has resulted in far less police involvement, thus, reducing the use of force (physical, tasers, OC spray) incidents upon patients. Additionally, this has also contributed to a reduction of Industrial Accident claims filed by responding police officers.	100%	100%	0
Communications	The first two employee open forum sessions with the CEO, COO and CNO to address regulatory news updates and general employee concerns were held with over 150 in attendance. Upcoming sessions will be scheduled every other month. The CEO participated in an interview with NPR on the changing demographics at KDMC. A press release was developed to promote the opening of the Women's Center which generated coverage in the local weekly press and an upcoming article in the LA Times. Navigant consultant Josue Rodas spoke for Hispanic TV station KCRA on capital projects at the facility. A meeting was held with the Community Clinic coalition to discuss image building at KDMC. Production has begun on a medical staff JCAHO-readiness newsletter which will be distributed to the PSA monthly. The monthly employee newsletter continues in production and continues to generate positive feedback.	100%	100%	0

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Case Management and Utilization	The Director of Case Management is on medical leave of absence (June 13 through August 13) and the Manager of Social Services is suspended pending the results of an investigation. These factors are preventing significant progress on workplan activities. The focus over the next several weeks will be on recruitment of a Supervisor of Social Services and re-evaluation of workplan status and recommendations. There will be continued focus on efficient transfer of ventilator dependent patients to long term care facilities through the realignment of community social workers. Efforts will continue to refocus medical social workers on providing professional services to patients and their families such as grief counseling versus taxi vouchers. Labor issues have been resolved to provide after hours/on call services by social workers. A formal two week notice of on-call schedules to be provided and will be effective July 20. Progress implementing interdisciplinary rounds continues. Nursing is supportive and believe the results are positive. The timing and location of rounds is being modified to better accommodate physicians and increase participation.	27%	56%	8
Capacity and Throughput	The "one stop bed beeper" was initiated to improve bed flow with appropriate patient placement and transfer.	11%	92%	1
Physical Therapy	All of the recommendations have been completed and implemented. Clinical data is being collected on the clinical outcomes. The data will be tracked and monitored for a six-month period.	83%	100%	0
Emergency Services	There is continued education and reinforcement of the new ESI 5 Level Acuity System (supported by the Emergency Nurses Association and American College of Emergency Physicians) directing Level IV and V to Urgent Care. All nurses attended a required inservice on triage where requirements for reassessment, based on acuity level, were reviewed. Nurses have been assigned and remain in triage for all shifts to ensure continuity of care. A Decompression Policy has been developed to address actions to be taken to treat and move patients through the ED during both normal and overcapacity occasions. Physician coverage has been increased in Urgent Care with an additional physician covering 4:30pm to 11:30pm and an attending on each shift to facilitate turnaround of patients. New guidelines for the treatment of pediatric patients (14 years of age or less) have been developed and education of staff is underway. Pediatric patients that are in the ED meeting the following criteria will be transferred to a facility equipped to provide care to critically ill children: unstable, requiring monitoring and supported ventilation; require surgery; or may require a higher level of care. Patients meeting the criteria will be cared for by a registered nurse certified in Pediatric Advanced Life Support until transfer of care to appropriately trained staff. The ED attending and Charge Nurse will collaboratively determine when a pediatric patient should be transferred and a streamlined process has been identified to efficiently transfer the patient. ED nurses continue to participate in the Medication Event Task Force to review and analyze medication events and develop corrective actions. A redesign of medication order flow is being done to streamline and improve the process.	34%	95%	5
Perioperative Services	OR staff were educated on the proper techniques for the cleaning and handling of instruments and competency evaluations are in progress. The OR facility remodeling plan was approved by DHS and OSHPD . Color scheme and finishes were finalized. A new performance measure identifying reported cases of abusive behavior has been initiated to encourage reporting of abusive behavior and the management and improvement of the OR environment. The surgery "buck sheet", the tool used to schedule OR cases was automated to streamline the process and improve communication. Inspections were conducted of surgical instruments and those that were in disrepair were removed. Salvageable instruments were serviced and ordered new instruments needed to complete sets were ordered.	48%	94%	6

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Med Admin - Clinical Programs and Medical Departments	Recruitment for an Intensivist is progressing, a contract is being reviewed by candidate. Dr. Richard Findlay has been appointed as interim Department Chair of Pediatrics.	21%	100%	5
Med Admin - Medical Staff Affairs	The physician performance evaluation process has been redesigned. Final sign-off of the revised Resident Supervision Policy was completed with training and implementation underway. Physician attending presence in clinical areas has been increased with more active participation in care. The enhanced peer review program is targeted for approval at July 6 PSA Exec meeting. This program will include the addition of peer review, case review and malpractice information to individual physician files for use in credentialing and reappointment. A tracking tool to target input and a plan to gather data for the peer review files has been established and resources are being identified. A monthly Physician Manager Training Program has been implemented. Topics to date include HR issues and performance evaluations, regulatory compliance, ACGME accreditation, patient safety and quality. A revised hospital wide on-call schedule has been developed that is distributed on a daily basis. A process has been implemented using Affinity to ensure all admitted patients are assigned a credentialed attending physician for all patients. A comprehensive review of historical deaths has been completed to identify quality issues, approximately 200 patient charts (deaths and clinical events) have been reviewed. A case review tracking spreadsheet has been implemented to monitor and coordinate follow-up. Real-time departmental death and clinical event assessments have been facilitated to supplement QA nursing and medical director reviews. An assessment has been completed on all medical staff assessment (229 physicians and oral surgeons/dentists). Medical Staff Rules and Regulations have been revised to enhance compliance with JCAHO and CMS. Joint Medical Administration and GME program meetings have been conducted to coordinate residency programs and response to ACGME related issues.	21%	100%	2
Med Admin - Quality, Performance Improvement, Utilization and Case Management	The Event Notification Reporting procedure and Root Cause Analysis procedure presented to Medical Executive Committee and the Clinical Chairs. A review of Risk Management and IOP Committee minutes completed. Review of individual clinical department QA/PI committee minutes reviewed and a 'best of breed' identified. Additional resources have been identified to support the QA/PI initiatives and have begun to standardize all clinical department QA/PI programs and role out department education.	29%	100%	1
Med Admin - Administrative Issues / Medical Admin	Efforts continue to identify resources to complete the physician workforce analysis. The administrator is currently covering a significant portion of an assistant administrator in the physician administration area.	30%	N/A	1
Nursing Services - overall	Four new med/surg beds and two new ICU beds (ICU B) were opened to patients. CNO and Clinical Director recruitment continues; one additional candidate screened for CNO who did not proceed to round two. On June 1 "Charting the Course" for OB and Family Centered Maternity Care was conducted to design and plan changes in the delivery of service in preparation for renovations. A performance evaluation system was developed to improve completeness of evaluations by nursing department leadership. As of the end of June, nineteen (19) nursing department evaluations are out standing. Accountability by manager was established for every traveler to manage performance with expectations for performance being established at the beginning of a travelers orientation by the CNO/designee.	23%	82%	10
Psychiatric Services - overall	Renovations in the triage area are set to begin the week of June 27. A new medical clearance form was developed. Physician peer review has been initiated.	58%	98%	2

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Information Technology - overall	ORSOS has a signed PO in process for the planned upgrade and a group of IT staff and users met to discus opportunities to improve functioning. ANSOS software/hardware PO has been signed the hardware has been delivered. A database administrator is being recruited to complete the transition work. Materials is developing a local implementation plan for Online Requisitioning targeting implementation for July. COGNOS software will be used for managing the performance measures of the KDMC Implementation plan. Training for Congas was held May 2-11 for KDMC IT and related staff. PLATO software has been recommended/approved for clinical pertinence tracking for JCAHO preparation. The server installation is now in progress. The Fox HIPAA Assessment was reviewed and recommendations and action steps will be added to the workplan.	47%	90%	4
Health Information Management - overall	The Filekeepers purge project is scheduled to begin pending VPN installation for Affinity chart tracking access. Filekeepers staff will update Affinity chart tracking off-site as charts are purged from the file area. This will result in 1 year of active medical records remaining in the file area allowing HIM to relocate to another part of the hospital. The relocation will resolve current patient privacy issues. The MPI Cleanup project is underway. The issues with the outpatient problem list will soon be resolved. The outpatient coders will access the pharmacy system through the internet and print out the medication history and place it on the record at the time of coding. Coders are currently printing off the Problem List itself that includes the diagnoses. Coders are adding the allergies. The third component required is the medication history. The clinical pertinence project will expand it's scope with ten new contract coders to arrive within the next few weeks to allow medical record concurrent review of CMS and JCAHO requirements on each patient care unit. Plato software will be installed in July which will facilitate the reporting, analysis and the development of specific corrective action plans. At that time we will begin entering data that has been gathered over the past few months. The Critical Incident death review of deaths from January 2005 to present is almost up to date with approximately 20 charts remaining for nursing and physician review. The database should be complete improving the analysis and trending of issues including process factors.	75%	90%	6
Human Resources - overall	Human Resources continued active recruitments for the 8 key senior management positions as well as other critical vacancies. Monthly job fair/interview days are now being held on campus with a wide marketing distribution. Training for all level of employees is ongoing, however, during June, both Physicians and Nurses were provided training on timekeeping policies and procedures. A group focused on regulatory compliance continues to meet twice a month with emphasis on the HR management standards. Staff in the Performance Management unit continue to work on backlogged cases to reduce the workload. Site visits for the new timekeeping project were conducted and staff are working closely with the contractor to detail the parameters of the new system. Staff have completed the overall assessment of all worker compensation claims and are now moving forward to disposition many of the cases.	86%	100%	4
Radiology	The crisis related to radiologists staffing continues. We are aggressively pursuing 24-hour per day teleradiology services with final report reading to compliment all modalities and improve our ability to provide reports much more expeditiously.	40%	87%	4

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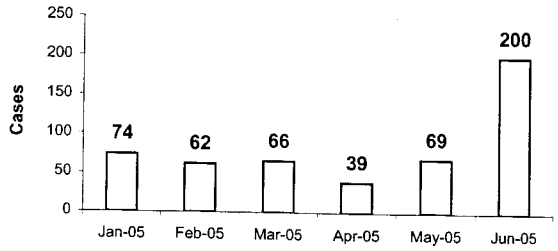
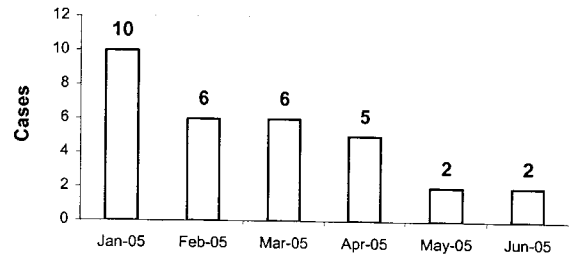
Laboratory/Pathology	The laboratory department completed its Point of Care Testing Operations Plan with focus on growth, standardization of testing, and improvement over the next 2 years. A reduction in blood culture contamination rates to under 2.7% has been achieved, which is below the national benchmark of 3%. The Pathology Department finalized its internal operation restructuring and enhancement plan, including significant improvements in workflow, customer service, and efficiency. On June 1, the laboratory officially established a process to file laboratory reports for inpatients directly in patient charts. As a result, laboratory reports are now available every morning for physician review prior to conducting their patient rounds. This process also meets CMS regulatory compliance. Laboratory staff continue to provide extensive hands-on training for nursing personnel in the areas of POCT and phlebotomy, including the creation of a 'weekly POCT clinic', which helps identify nursing staff having difficulty thus allowing for targeted training in phlebotomy and Point of Care Testing.	55%	96%	5
Pharmacy	The Medication Event Task Force is well established and continues to meet weekly, awaiting the PSA president to add a physician member. The Task Force developed a new Medication Event Reporting Form to be utilized for multidisciplinary reporting of all medication events. The group reviewed May 2005 trended medication event data and developed recommendations for corrective action. This analysis included the recommendations that are presented to the P&T Committee and the Quality Committee of the Board. The June 2005 pharmacy newsletter concentrated on medication event reporting, and was disseminated to all MLK employees. Currently awaiting a decision for physical relocation of outpatient pharmacy and the clinical pharmacy office. A revised dangerous abbreviations policy and high alert medications policy were approved by P&T Committee this month, and forwarded to Med Exec Committee for approval. The purchase order for Chapter 797 IV Room design consultant was approved and a plan to identify physical plant changes required to comply with this JCAHO regulation are underway. The Omnicell cabinets on nursing units were upgraded to include barcode scanner technology to facilitate replenishment utilizing barcode scanners to increase accuracy (medication safety).	47%	76%	9
Cardiology	Finalization and initiation of the implementation of the work plan.	0%	0%	0
Neuroscience	Finalization and initiation of the implementation of the work plan.	0%	0%	0
Ambulatory Services - overall	Accountabilities for implementation need to be established once recruitment for the vacant leadership position is successful.	0%	N/A	0
Programs & Services - overall	Initial draft of Recommendations to be reviewed and revised with action step, timelines and accountabilities established.	0%	N/A	0

King/Drew Medical Center
Hospital-wide Performance Measures

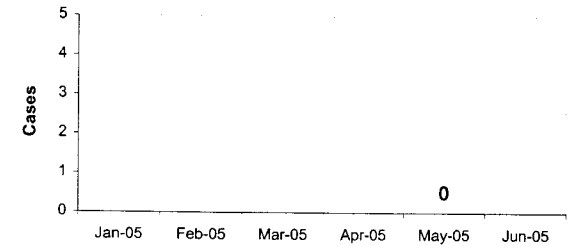
Medication Errors (NCCMERP Categories B-I)



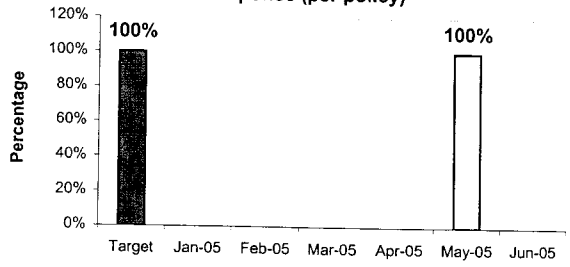
Falls



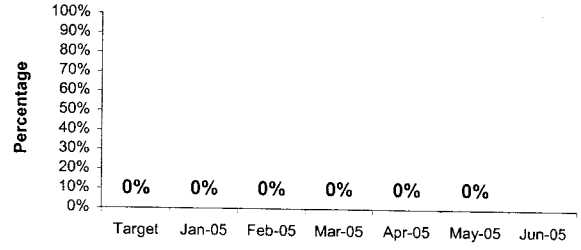
Number of Sentinel Events



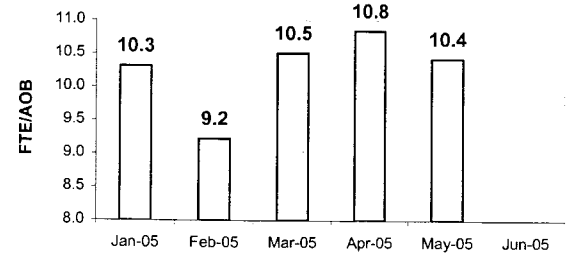
Percentage of cardio-pulmonary resuscitations with ACLS protocol followed and appropriate team response (per policy)



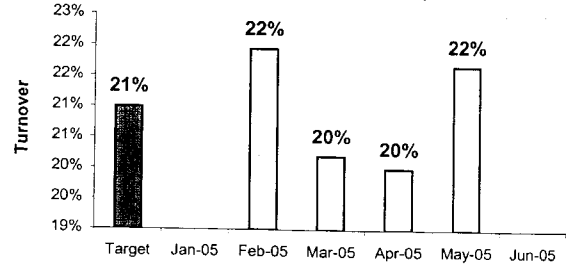
Percentage of Code 9 incidents resulting in patient/family injury



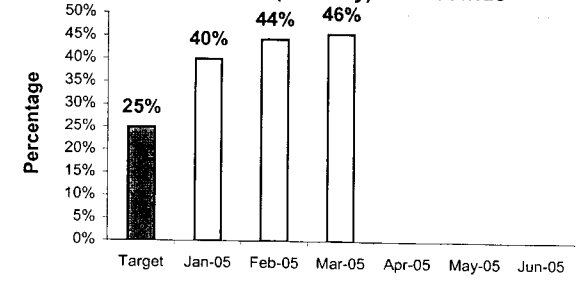
KDMC Paid FTEs per AOB



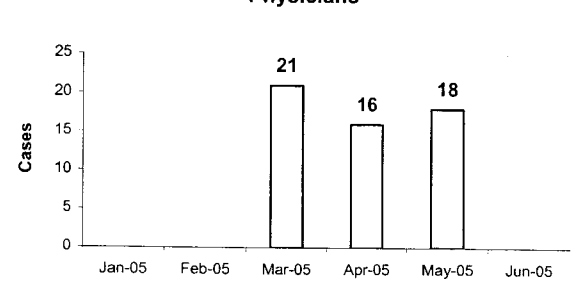
Turnover rate (KDMC Supervising Staff Nurses, RNs, and LVNs)



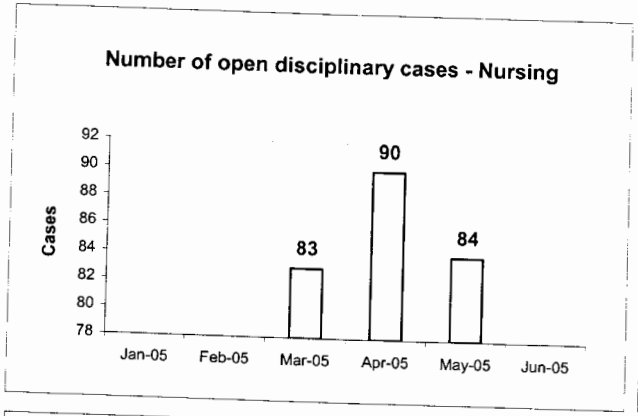
Percentage of Traverler/Registry hours to total productive hours (RN Only) - Housewide

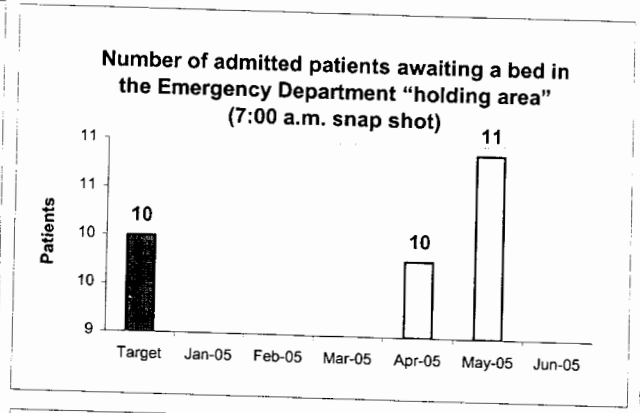


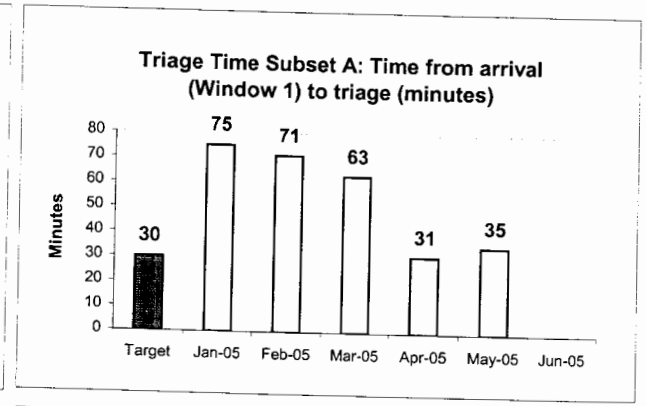
Number of open disciplinary cases - Physicians

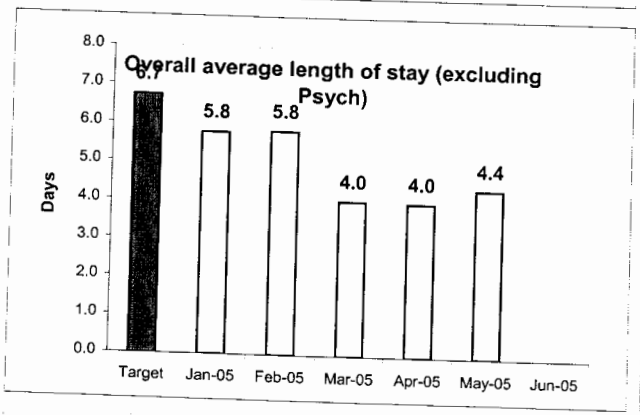


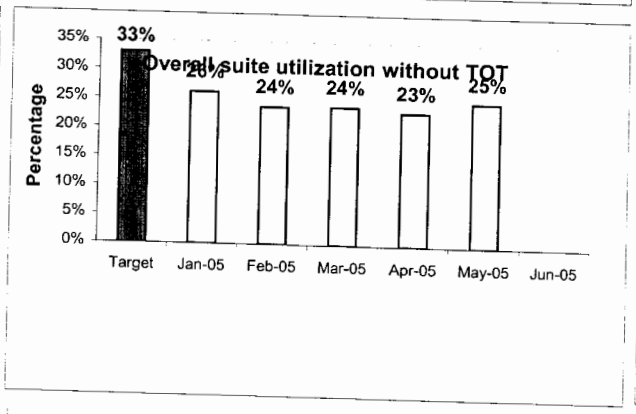
File: KDMC Performance Measures Rollup 7-8-05.xls

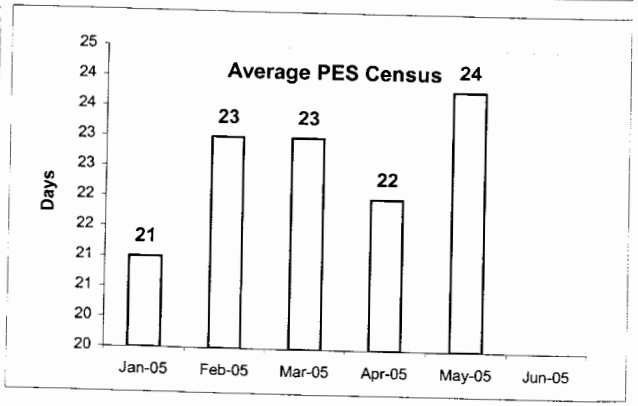

Number of open disciplinary cases - Nursing
Cases
92
90
88
86
84
82
80
78
83
90
84
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05

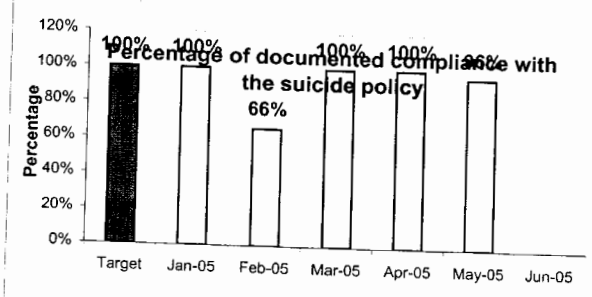

Number of admitted patients awaiting a bed in the Emergency Department "holding area" (7:00 a.m. snap shot)
Patients
11
11
10
10
9
10
10
11
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05

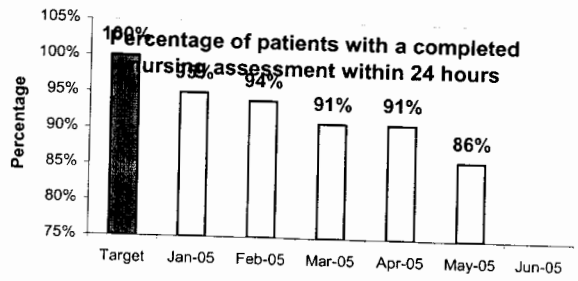

Triage Time Subset A: Time from arrival (Window 1) to triage (minutes)
Minutes
80
70
60
50
40
30
20
10
0
30
75
71
63
31
35
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05

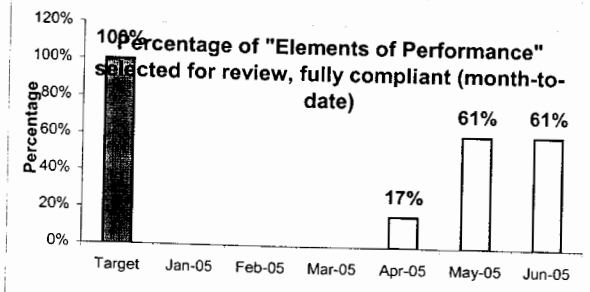

Overall average length of stay (excluding Psych)
Days
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
6.7
5.8
5.8
4.0
4.0
4.4
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05

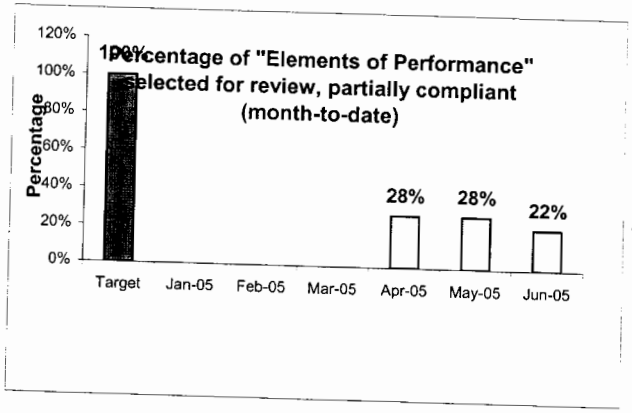

Overall suite utilization without TOT
Percentage
35%
30%
25%
20%
15%
10%
5%
0%
33%
26%
24%
24%
23%
25%
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05


Average PES Census
Days
25
24
24
23
23
22
22
21
21
20
20
21
23
23
22
24
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05


Percentage of documented compliance with the suicide policy
Percentage
120%
100%
80%
60%
40%
20%
0%
100%
100%
66%
100%
100%
96%
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05


Percentage of patients with a completed nursing assessment within 24 hours
Percentage
105%
100%
95%
90%
85%
80%
75%
100%
94%
91%
91%
86%
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05


Percentage of "Elements of Performance" selected for review, fully compliant (month-to-date)
Percentage
120%
100%
80%
60%
40%
20%
0%
100%
17%
61%
61%
Target
Jan-05
Feb-05
Mar-05
Apr-05
May-05
Jun-05



Note:
- Data collection of Turnover rate was started in February 2005. Likewise, data collection of Open disciplinary cases (separate by physicians and nursing) was started in March 2005.
- Data collection of "cardio-pulmonary resuscitation (code blue) compliance percentage" was started in May 2005.
- Data collection of "ED holding patients" was started in April 2005.
- Data collection of "Elements of Performance" compliant percentage was started in April 2005.
- Monthly data compilation of sentinel events and unexpected death started in May 2005.
- Registry/travelers hours are currently being investigated.